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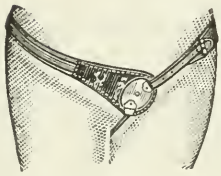

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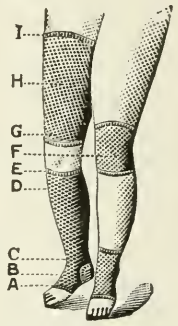

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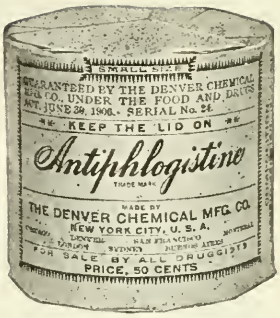
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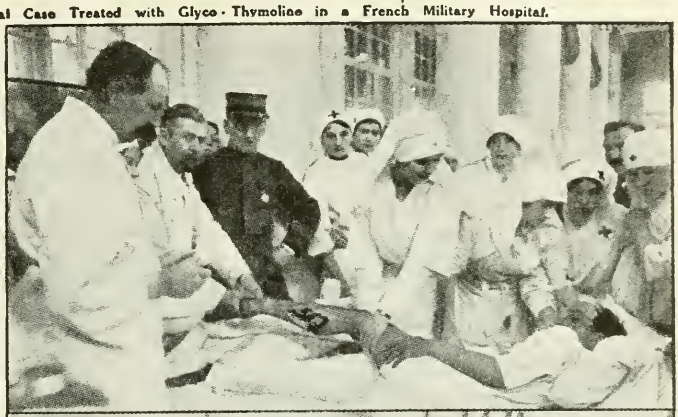

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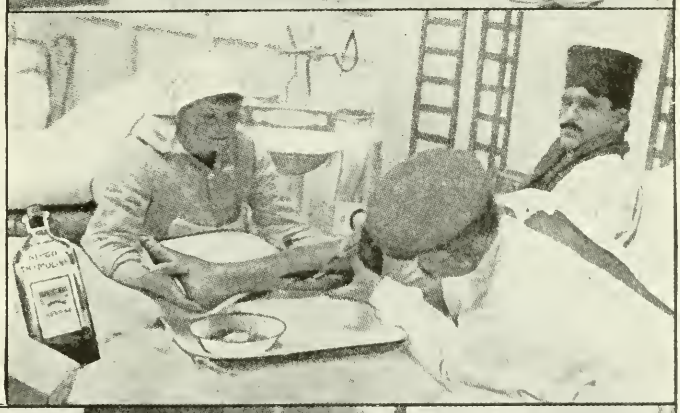

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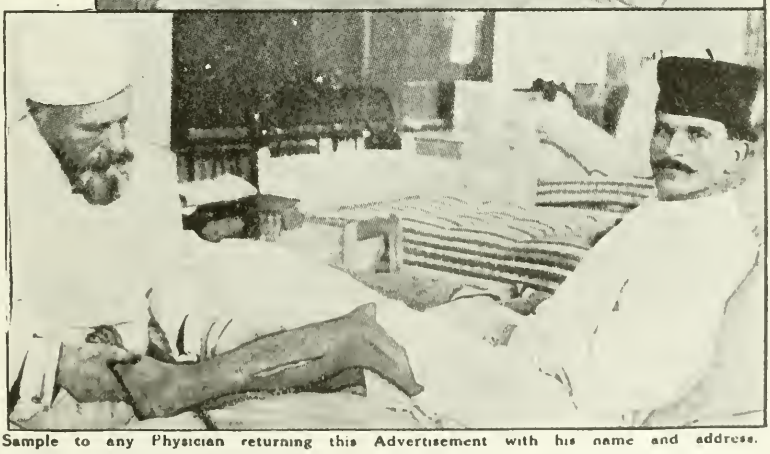

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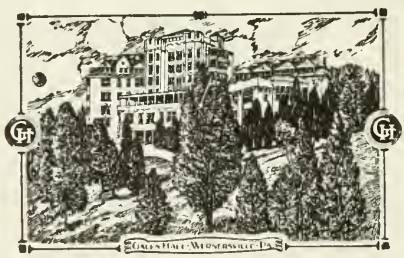

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A Journal of Medicine and Surgery
Vol. LIX, No. 2 BALTIMORE, FEBRUARY, 1916 Whole No. 1173

ON THE EARLY RECOGNITION OF CANCER OF THE STOMACH.*

By Julius Friedenwald, M.D.,
Professor of Gastroenterology, University of Maryland School of Medicine, and College of Physicians and Surgeons, Baltimore, Md.

We must all realize the great importance of the early recognition of gastric cancer, for unless the diagnosis of this affection be made early, the result of surgical interference can only be in the nature of relief, and not of cure. The gravity of this statement can be more fully realized when I point to the fact that of a series of 266 cases of my own operated on, there is not a single patient living.

The diagnosis of cancer of the stomach is exceedingly simple when the disease is fully developed, but when the affection is still in its incipiency there is nothing more difficult; for it is a well-recognized fact that the earlier the stage of the growth the less positive are its manifestations. If one analyzes a series of cases of gastric carcinoma, one finds that the patients developing this affection are not, as a rule, chronic dyspeptics, and, excepting in those instances in which the disease has developed from a previous gastric ulcer, have usually been in good health, with a normal digestion, until the onset of this disorder. That the onset of this affection is sudden in a large proportion of cases is a fact of great value in the early diagnosis of this disorder.

In arriving at an early diagnosis, the most important signs and symptoms must be taken into consideration.

1. Anorexia.—Anorexia is a very prominent symptom of gastric cancer, and was present in over 89 per cent. of our cases. It varies markedly from a slight loss of appetite to an absolute aversion to food.

The aversion for meat, which frequently occurs early in the disease, is of some diagnostic importance.

2. Vomiting.—Vomiting is also of frequent occurrence in gastric cancer, appearing in 89 per cent. of our cases, in 67 per cent.

*Presented at the meeting of the Medical Society of the University of Maryland December 14, 1915, and abstracted from the New York State Journal of Medicine July, 1915.

of which it was in no way associated with the ingestion of food. While this symptom is exceedingly frequent, it occurs so irregularly and bears such slight relationship to food that it can be accorded only minor importance in diagnosis.

3. Pains.—In our cases pain was present in 93.1 per cent. It was present as an early sign in 84 per cent. of our cases, but on account of its variation as to location and extent its diagnostic significance as an early sign of gastric cancer is lessened.

4. Hematemeses.—Gastric hemorrhages occurred in 22.7 per cent. of our carcinoma cases, of which 88.7 per cent. were multiple and 10.8 per cent. single hemorrhages. It appeared as an early sign in 21 per cent. of these cases, and as a late sign in 79 per cent. Inasmuch as gastric hemorrhage appears early only in a small proportion of cases, this sign can only rarely be relied upon as an early sign of this disease, but when it occurs, especially in the coffee-ground form, it presents additional evidence in the diagnosis.

5. Melena.—Tar-colored stools appeared in 18.9 per cent. of our cases, much less frequent than hematemesis, but in only a small proportion of these cases did it appear as an early sign, that is, in 14 per cent., while it appeared late in 86 per cent.

Occult Blood.—A positive reaction for occult blood was obtained in 92.5 per cent. of our cases. When occult blood is once observed it can usually be found at any time afterward. The presence of occult blood is a very constant as well as an early sign of gastric cancer.

6. Dysphagia.—Dysphagia existed in 6.9 per cent. of our cases, that is, in those cases in which the growth involved the cardiac orifice. It appeared as an early sign in 78 per cent. of these cases, and, according to our experience, when present in patients over 40 years of age is a sign of great significance.

7. Loss of Flesh.—Loss of weight is a sign of considerable value. It occurred in 98.5 per cent. of our cases, in which there was a loss of flesh of from 5 to 78 pounds. This sign is of importance as an early sign of cancer, yet periods of improvement with gain of flesh are not uncommon in the early period of the disease, and this should be borne in mind in the early diagnosis of gastric cancer.

8. Presence of Palpable Tumor.—While the presence of a palpable tumor is the most valuable diagnostic sign of gastric cancer, yet this sign is usually a late manifestation of the disease.

9. Dilatation of the Stomach.—Dilatation of the stomach due to pyloric stenosis occurred in 47 per cent. of our cases, and this condition when present early is of the greatest diagnostic value. It occurred as an early sign in 52 per cent. of our cases of gastric cancer.

10. Ascites and Edema of the Extremities.—Ascites or edema appeared in 21.1 per cent. of our cases, but only in 24.6 per cent. of

these cases were these signs presented before the first six months after the first appearance of symptoms, indicating that both ascites and edema are late manifestations in gastric cancer.

11. Certain Roentgenological Findings.—Roentgen-ray examinations have been of great help in many instances in the diagnosis of gastric cancer. Inasmuch as the largest proportion of cancers have their seat at or around the pylorus, early obstruction is not infrequent. In the early stages of this disease the obstruction is incomplete, and it is only by means of the X-ray that beginning or partial obstructions of the stomach can be determined.

The most important X-ray evidence, however, of cancer is a filling defect, which remains constant in all of the plates. When the disease has been present for some time, this is in advanced cases, the defect is large and very irregular, and there is an absence or peristalsis at this area. In the early cases, however, there is but a slight thickening at the cancer area, with weakened peristalsis, which usually makes the diagnosis exceedingly doubtful and even at times impossible.

12. The Gastric Secretion.—In 89 per cent. of our cases there was an absence of free hydrochloric acid. The absence of free hydrochloric acid is an early sign in many instances, and when taken in conjunction with other symptoms, is a sign of real importance, and yet an absence of hydrochloric acid is so frequently observed in affections other than cancer that this sign loses much of its significance.

It appeared as an early sign in 76 per cent. of our cases. The diagnosis of cancer is greatly strengthened when in the absence of free Hcl lactic acid is found. The Oppler-Boas bacilli were observed in 79 per cent. They were found only in those instances in which lactic acid was observed, and appeared as an early sign in 74 per cent. of our cases. This finding, when accompanied by the presence of lactic acid and an absence of free Hcl, is a sign of great diagnostic importance.

The Wolff-Junghans Test.—We have utilized the Wolf-Junghans test in 52 of our cases of gastric cancer. In all of these cases there was an absence of free hydrochloric acid. In 44 cases (84.6 per cent.) there was a positive reaction obtained. Of these, 14 were early cases, and the reaction was positive in 11 (79.5 per cent.) This test is an extremely valuable sign when positive in the early diagnosis of gastric cancer, especially when there is an absence of free hydrochloric acid, and when lactic acid is present in the gastric contents.

13. Sero-diagnosis by Abderhalden's or Kelling's Methods.—Inasmuch as many of the signs and symptoms of gastric cancer are often indefinite and late manifestations of the disease, it has been hoped that serum tests might reveal early evidences when the physical signs are yet indefinite and misleading. It must be remembered, however, that in order that conditions favorable for obtaining positive reaction may exist, the growth must have

assumed at least such proportions as to produce a generalized blood reaction with ferments or with antibodies in the blood.

I. Abderhalden's Serum Test.—My colleague, Dr. Charles E. Simon, has tested this reaction in a number of my cases of gastric carcinoma, and finds that the reaction cannot be considered specific for this disease, for there may be a variation in two directions, as there may be failure to get the reaction in undoubted cases of malignancy, and on the other hand, there may be obtained a positive result in conditions which are not malignant.

II. Kelling's Serum Test.—Recently Kelling has described a serum test for the diagnosis of carcinoma based on the fact that the serum of patients affected with cancer possessed the property of dissolving the red corpuscles of certain other species, notably the hen. He noted the hemolysis after incubating equal parts of the diluted serum in a 5 per cent. suspension of hen's corpuscles for 24 to 48 hours. Kelling found that this test gave positive reactions in 90 per cent. of cases of gastric cancer.

Dr. Simon has tested this reaction in a number of my cases of gastric cancer, and finds that it is in no way specific of this disease. The reaction occurred in other conditions, and was not present in a number of cases of cancer.

In drawing our final conclusions concerning the significance of the various signs and symptoms of gastric cancer, it is quite evident that many are general manifestations frequently present in other gastric affections, and not characteristic of this condition alone, while those which are more characteristic are usually late developments. On this account, the late diagnosis of cancer is rendered exceedingly simple, while on the other hand, the early diagnosis is, however, exceedingly difficult.

In reaching definite conclusions, it is therefore important to rely not upon a single sign or symptom, for there are no pathognomonic signs of early cancer, and only after a critical review of the history, physical examination and study of the symptoms, including examination of the gastric contents and stools, can definite conclusions be drawn.

Inasmuch as surgery offers the only cure for gastric cancer, and then only when the diagnosis is made early, the question of early diagnosis is of the greatest importance. How can this be made?

As yet it is impossible to reach very definite conclusions at the early stage of the disease, except in rare instances. But it behooves us to carefully observe all of our cases of gastric disturbances most carefully, and to view with suspicion all patients over 40 years of age who show no improvement after a short course of medical treatment.

Inasmuch, therefore, as our means of arriving at an early diagnosis of cancer of the stomach are exceedingly insufficient, and until more certain methods of diagnosis are available, exploratory incisions should be urged upon all individuals over 40 years of age having gastric symptoms which are not relieved after a few

weeks of treatment; especially is this the case if the patient presents a history of rather abrupt onset, some loss of flesh, an absence of free hydrochloric acid in the gastric contents and occult blood in the stools.

Even under these conditions many cases will be operated on too late, for there can be no question but that gastric cancer may be present for some time and may assume considerable proportions even before marked symptoms of indigestion are manifested.

SURGICAL TREATMENT OF GOITER.

By Robert Parke Bay, M.D.

In considering this subject, the treatment of various lesions involving the thyroid gland, with special reference to the advisability and results of surgical interference, it is necessary to have a fair knowledge of the character of the tumor. For this reason it is necessary to divide diseases involving the gland into several classes.

First, in the clinical classification, we may consider the simple and toxic form.

In the anatomical classification we recognize two forms, the diffuse and nodular.

The diffuse type of hypertrophy may show itself in two forms: (a) Colloid goiter. In this form the amount of colloid is so greatly increased that the follicles of the gland are often greatly dilated, and the epithelium lining of the same more or less flattened or destroyed in some cases. The septa between neighboring follicles may be broken through and absorbed. If sufficient dilation and confluence of follicles is brought about we have the cystic condition (cystic colloid goiter). (b) Parenchymatous goiter. This form consists in the glandular proliferation, or more closely resembles a new growth. Solid masses are formed much in the same way as the fetal thyroid is formed. The colloid is small in proportion in this form, but we have an increase in the cellular elements, and consequently the following: The first type represents the simple, while the second is the type associated with hyperthyroidism.

It is not always the largest goiter that produces the most marked symptoms; in fact, it is frequently the reverse. It is also well known that all goiters are not necessarily surgical conditions, and it is my opinion that all enlargements of the thyroid should have medical treatment before an operation is advised. This not only may cure the condition in many cases, but will be of value preparatory to an operation.

The medical treatment, briefly, should consist in rest, electricity and calcium lactate given in large doses internally for several months, after which time, unless marked improvement has taken place, an operation should be advised.

The question necessarily arises, What symptoms demand surgical interference? In simple goiter many have them performed for the cosmetic effects, but the great majority have an obstruction to the respiratory passages, or pressure on the trachea. Occasionally we have a substernal goiter the result of massage, or osteopathy, as one of my cases was changed from a simple hypertrophy, with no symptom, except the enlargement, to a dangerous and troublesome condition, the result of massage. This goiter could only be seen in the suprasternal notch during swallowing. The interference with respiration was marked, the patient being unable to sleep unless propped on pillows, and being in constant fear of suffocation. The symptoms entirely disappeared following thyroidectomy.

All cases of goiter-producing symptoms which have not been benefited by medical treatment should be operated upon, namely: Such symptoms as (a) distress from pressure upon the trachea, or esophagus, (b) pains from pressure, (c) unsightly deformity, (d) discomfort due to weight of an enlarged gland, (e) increasing symptoms of hyperthyroidism not yielding to the medical treatment.

The character of operation depends largely on the symptoms presenting themselves; for instance, the cystic goiter may be relieved by the simple enucleation of the cyst, while the severe case of hyperthyroidism, with vasomotor disturbances, tremors, mental irritability, tachycardia, loss of weight, myocarditis, kidney changes and marked exophthalmos, are best treated by first ligating the vessels, and, after the symptoms have subsided, the removal of the gland. The above symptoms are frequently seen in a mild degree with only slight enlargement of the gland. These cases have frequently been treated for neurasthenia, gastritis and other nervous conditions. Many have even been advised to enter some institution for mental diseases, with little or no prospect for a future. One of my cases represents this class, where a young girl was advised to enter an institution for feeble-minded and told she was not likely to ever be of service to herself or family. After the removal of two-thirds of her thyroid, which was only slightly enlarged, she was completely cured, and has taken up the profession of nursing, leading a class of 20 others, and, while not a robust individual, enjoys good health, with occasional slight nervous symptoms following the loss of rest. These cases are frequently noted following an acute infection about the throat or sinuses, and if taken early will respond to medical treatment. Two cases are under observation at the present time which could well be termed an acute inflammation of the thyroid, the patient awakening with pressure symptoms in the throat, with an enlargement and tenderness on pressure over the thyroid gland, with slight fever and marked acceleration of the pulse. Both cases were preceded by an infection of the tonsils, one involving the antrum.

Both cases are being treated by a specialist, and the symptoms are apparently subsiding.

During the last 10 years the operation of thyroidectomy has changed in the minds of the surgeons and also the laity. It was formerly looked upon as one of the most dangerous of all major operations, while at the present time it is looked upon as one of the safest major operations. This paper embraces 25 consecutive operations without any mortality. The dangers not to be overlooked and to be fortified against are (a) anesthetic, (b) shock, (c) hemorrhage, (d) hyperthyroidism, (e) infection, (f) injury to the recurrent laryngeal nerve, (g) injury to the parathyroid glands, (h) air embolism, (i) collapse of the trachea with asphyxia.

CHOICE OF ANESTHETIC.

Ether has been universally used in my cases, with good results, and I feel, with far more satisfaction and with less shock, than any of the local anesthetics. The anoci method of Crile was used in two cases without any appreciable effect: it prolongs the operation, and therefore increases the danger. The anesthetist should be an expert, and should prepare in the same manner as the surgeon and assistants, wearing rubber gloves with sterile gown. The ether mask and coverings should be sterilized, and the ether can covered with sterile towels. This enables the anesthetist to hold the patient's jaw forward, also to keep the head still, and does not obstruct the field of operation. The anesthetic should not be started until the patient is completely prepared. The iodine preparation of the skin is advisable, as it does not require washing or manipulation of the gland. The patient is placed in a semi-upright position, with a small pillow under the shoulders, throwing the gland forward as prominently as possible. Shock is seldom encountered, as the operation is of short duration and attended with little loss of blood. Hemorrhage of any consequence is seldom noted, and is controlled by the ligation of the suprathyroid vessels and by clamping the vessels as they enter the capsule, as all operations should be performed within the capsule.

Hyperthyroidism following operation is the real danger to your patient. It is due either to absorption of the thyroid secretion pressed out of the gland and into the circulation, or of thyroid secretion of toxic blood absorbed from the wound surface. The latter is, in my opinion, the chief cause, and to combat this I have kept a constant stream of sterile salt solution flowing during the operation, so preventing blood from remaining on the surface and being reabsorbed. The results have been more than satisfactory, as shown by these cases, and in none of these cases have the thyrotoxic symptoms been increased following operation.

This is not difficult to perform, the only disadvantage being the wet dressings, which amounts to little, as no case has developed bronchitis or pneumonia, and results are very gratifying.

Parathyroids and the recurrent laryngeal are never injured if

the operator stays within the capsule, as they are both situated behind the capsule.

The after-results following partial thyroidectomy have been very satisfactory, and in only one case did the portion left show any signs of hypertrophy, and that not to such an extent as to require its removal. The steps of the operation I will not describe, except to say that the transverse incision should be made as low down as feasible, and all cases should be drained. It is seldom necessary to cut across the muscles, as they can be retracted and after the delivery of the gland act as support during operation. The capsule and fascia should be sutured with catgut, and a subcutaneous silver wire suture is used to close the skin encircling the tube, and after the drains are removed this is pulled tight, almost completely closing the external opening. The drainage is continued from 48 to 72 hours, and during this time the cavity is irrigated with sterile salt solution every 24 hours. After a few months the scar is hardly perceptible, easily hidden by a string of beads, thereby not interfering with a low-neck gown. These cases, while not a large number, present some rather interesting conclusions:

First—Thyroidectomy is not attended with the high mortality that was formerly believed.

Second—The results of thyroidectomy in all classes have been very gratifying, the mild and severe thyrotoxic symptoms clearing up with marked rapidity.

Third—Enlargement of the thyroid gland, with over activity, frequently follow acute infections about the throat, mouth and sinuses, leading one to believe that infection is an element in the etiology.

FIRST AID INSTRUCTION TO POLICE FORCE OF BALTIMORE CITY.

By Joseph M. Craighill, M.D., Chief Surgeon.

(Letter to Secretary of the American First-Aid Conference).

My Dear Doctor—In reply to your letter as to what has been done relative to first aid to injured by the Police Department of this city, I enclose the report of Lieutenant George E. Lurz, who has been a most efficient teacher and takes great interest in his work.

In the latter part of 1913, or early 1914, I was ordered by the Police Board to look into establishing first aid instructions to the police force as far as practicable.

After investigating the Pennsylvania Railroad mode of instructions and writing to Major Patterson of the Red Cross organization, I obtained a number of first aid books gotten up by that society and distributed them in the department, where I thought

they would be useful in disseminating the knowledge I wished to impart.

It was hard for me to decide just how much instruction these men should receive, also how to get them informed about first aid subjects without making them think they had missed their calling by not being medical men.

Another difficulty about said instructions was that it takes the policeman away from his beat more than he could well be spared in a city where we need at least 100 to 200 more men than are on the roll at the present time. The present available force is about 700 men, with an average of from 25 to 50 men constantly on the sick report due to sickness and injury.

My first efforts of instruction were to give a few talks to the captains of the department and to distribute a first aid book to each one. Later, I came to the conclusion that I had started at the wrong end of the line; the probationer policeman was the man to teach and gradually work on up the line toward the captains.

With this idea in mind, it was thought best to have this subject taught at the regular school of instructions of this department, located at the Northern Police Station. These young men are there put through a regular course of training until they are proficient enough to graduate, and the first aid course was installed in this curriculum. Lieutenant Lurz, assisted by the instructor in the gymnasium, Officer Lynch, doing the teaching. These two officers were personally instructed by me, making a study also of the various first aid books and attending lectures when they could on this subject.

Lieutenant Lurz had been a teacher before he became a policeman, so his help has been very effectual. His instructions have been along the lines of simplicity to enable the policemen to aid the sufferer until he could be gotten into a nearby hospital; also how to do artificial respiration in gas poisoning; how to handle a man who had been overboard, etc. These men have also been instructed as to what not to do, which I think is nearly as important as the reverse. They are taught how to handle a wounded man by actual demonstration, how to get him to the ambulance, how to apply temporary splints, etc.

After starting the instructions to the men, the next problem to solve was, how the policeman could get a first aid package when needed. Already a very much encumbered man, with his pistol, handcuffs and other things he is required to carry, I did not think it advisable to add a first aid package to his equipment. Noting a space in the lower part of each patrol box, I concluded if the first aid package could be made of a proper shape, a package in each box, it would be available not only for the use of the officer or for any passing doctor who might be trying to help out in an accident case on the street. With this idea in view, I wrote Major Patterson on the subject. He came to Baltimore and thought well of my suggestion and made a package for the department of the

proper size and shape. This package, it is needless to say, has been useful on many occasions, but this system might be improved on by possibly having a special box provided attached to the patrol box. The package contains a bandage, which the men are instructed how to open up without touching the pad which is to go next to the wound; also a triangular bandage, which can be used for all kinds of temporary uses, and two safety pins. Owing to the fact that the police patrol wagon is the only public ambulance service in the city, it was thought advisable to place some first aid packages, bandages, etc., in each wagon; also an outer splint, to extend from the axilla down the outer side of the body, and a shorter inner splint. I also had made for each wagon five leather straps, three shorter ones for the leg and two longer ones for the trunk. As you will see, the patrol wagon men, 51 in all, have been instructed how to use these appliances on injured people in getting them into a hospital.

Soon after starting our first aid work the Red Cross Society sent an instructor in swimming to this city, who gave lessons not only in swimming, but how to rescue and resuscitate the drowning man. All policemen around waterfronts were given instructions by him.

This gentleman also prevailed on the Police Department to place, on the different piers about the city, life lines with a cork buoy big enough to hold a man up in the water. I am informed quite a number of lives have been saved by the aid of these buoys.

To sum up to the present time, 348 men have been instructed. All those coming on the force are sent to the school of instruction, and gradually all others of the younger men will in time be sent to the school of first aid.

* * * * * * * * * * *

This letter of Dr. Craighill gives in brief what has been done towards instructing the police force of Baltimore City on first-aid methods since 1913.

Teaching of police officers about measures to be employed in the first treatment of injured individuals and in transportation is by no means an innovation. I distinctly remember when I was a medical student at the University of Pennsylvania, between the years 1888 and 1891, that Dr. J. William White, then associate professor of surgery at the University, was giving instructions on first aid to the police force. I do not know whether first-aid instructions were ever given before to the police force of Baltimore, but it seems to be the consensus of opinion that police officers should receive some instruction. The suggestion of Dr. Craighill that this instruction should be given the police officers during the probationary period is a good one.

The Secretary of the American First-Aid Conference has been authorized by a resolution to make a survey of the entire question of first-aid instruction and material among railroads, mines, industrial plants, in the police and fire departments and among the laity.

The National Board of First-Aid Standardization has been appointed by the President of the United States, and will endeavor to standardize material, methods, and what should be taught. There is no reason why there should not be a uniform system for the instruction of police officers throughout the United States and Canada.

The beginnings that have already been made in Baltimore coincide with the views of the majority interested in this subject, and it will be very interesting to have a report from Dr. Craighill from time to time as to the results that are obtained.

I hope to make a survey of what is being done throughout the United States and Canada on first-aid by the police and make a report later.

It seems best in the beginning to give the simplest instructions and to employ the simplest forms of first-aid material. No progress will be made unless there are careful records which will allow an investigation of the results obtained.

I congratulate Dr. Craighill on his beginning, and trust that he will be able, after a longer experience, to make a definite report on the results obtained.

JOSEPH C. BLOODGOOD,
Secretary First-Aid Conference.

904 North Charles street.

THE THREE PHASES OF LIFE.*

By Clement A. Penrose, M.D.

ALTHOUGH greatly pleased by the honor of the invitation from Dr. Platt to address the graduating class of nurses of the Robert Garrett Hospital for Children, I was somewhat oppressed by two facts. First, the limited time at my disposal to prepare a suitable paper, and second, that Dr. Whitridge Williams was also going to speak at the same time. I knew from of old that he, a most versatile man, would leave very little unsaid, and I felt anxious to avoid the sad position of one who is forced to repeat the good points already brought out with the preface "as has been mentioned, or called to your attention, etc.," by the previous speaker.

To extricate myself as far as possible from such a deplorable position, I decided to wander somewhat from the usual lines of these addresses to nurses and take up a broad problem from a viewpoint which has been a great help to myself. I trust that the earnestness of my endeavor will more than overcome any flaws in the exposition of such a great subject.

I feel certain from my knowledge of your excellent hospital, its

*An address made March 17, 1915, to the Graduating Class of Nurses of the Robert Garrett Hospital for Children, Baltimore, Md. Published in part in the *American Journal of Nursing*, September, 1915.

Faculty and Board of Managers, that this graduating class is fully equipped in every way for taking care of children in all the various duties thereto appertaining. However, the troubles of a trained nurse do not end here. You are going out from the protecting influences of your "Alma Mater" and must come into intimate contact with a great number of different people, represented by the parents, grandparents and other relations of the children under your care, the people of the neighborhood in which they live, their ministers and teachers, and, probably worse than all, the strange doctors. Equipped as you are, I believe that the main difficulties in your work will come from these sources rather than the actual care of the children. It is along this line that I propose, by giving you a conception of what is normal in life, to urge you to be more tolerant of the abnormal traits and characteristics met with in other people.

This is Saint Patrick's Day, the day sacred to the memory of the Patron Saint of Ireland. Tradition says that he removed all the serpents from this country, and I believe that none are to be found there now, if they ever really existed. It is most probable that these serpents represented rather some of the faults and sins of the Irish people—the snakes in their bosoms, as it were—which the good teachings of Saint Patrick were able to purge from them. In this sense, we all of us carry serpents about within us, among the most poisonous species being those of egotism and selfishness, without tolerance of the views, opinions and lives of other people. This is often due to the fact that we simply represent different stages in life from the person we are opposed to, accounted for by actual differences in years or by different methods of bringing up. Tolerance is the most important asset in a nurse's life. It will enable her to exist happily in every new environment in which she is placed and greatly increase her general efficiency. I therefore present the following aspect of life for your consideration, hoping that it might help you in your relations with other people, as it has helped me.

Under normal conditions life can be divided into three phases.

First—The phase of the body, in which the youth in his growing physique feels and meets more or less incompletely the demands of his physical being, athletic games, dancing, a military life, the instincts of sex, etc.

Second—The phase of the mind when such enterprises are no longer satisfactory. A higher mental being has been created, often somewhat at the expense of the body, which is now unable to bear any great physical strain. The individual turns to more intellectual pursuits, which may carry him into active business or the realms of science, literature or philosophy, etc. In these vocations the same desire to excel or take a superior place in the world is manifest even in an increasing degree. This is essentially the ambitious

period of life, tempered, however, by experience, foresight and a more mature judgment.

Third—The phase of the spirit, the meaning of which term I shall not here attempt to define, but rather let my illustration explain. In this phase the bodily desires and satisfactions are practically nil; the mind, having attained the fruits of its efforts, finds them less sweet than was anticipated. Not functioning with the same degree of excellence as in the previous years, it is constrained to seek a less active sphere, where there is more time to consider the welfare of others.

The man or woman who has attained this ultimate perfection of life, a ripe old age, normally turns from the ambitions of the world to the serious contemplation of life's end and their own preparedness for this end. They are inclined to take up acts of philanthropy and mercy, and to enjoy more than ever the companionship of their grandchildren.

The biographies of men and women who have accomplished great things illustrate this point most accurately, as well as our own personal experiences with such lives. Material acts of philanthropy from great business successes like Andrew Carnegie, John D. Rockefeller, Henry Phipps, etc., who have endowed universities, hospitals, laboratories, libraries, etc., or made great art collections, are not, as many would infer, the acts of conscience-stricken individuals, but are the actual necessities of lives that have been so productive in other ways. They must develop the spiritual side of their existence as a proper culmination of such great mental activity in the past. In the case of great teachers, philosophers, scientists, etc., the material evidences of such a trend may be lacking. We will, however, find in their writings, their teachings or addresses evidences of this spiritual evolution, which in some instances becomes almost fanatical in its manifestation.

Sir Isaac Newton, who lived to be 85 years of age, drew the conclusion from his successful investigations of Nature of the existence of a supreme being.

Alexander Von Humboldt in the latter days of his life became very charitable.

Louis Agassiz, the famous Swiss scientist, gave evidences of this spiritual growth in his declining years, when he remarked to a friend "that a species is a thought of the Creator."

Sir Oliver Lodge recently professed his faith in a public lecture.

Our own Osler wrote a few years ago his "Science and Immortality."

These are but a few of the many illustrations which I could bring to demonstrate this point. The reason for this spiritual development as age advances in these great lives I shall not attempt to explain here, even if I could. The fact remains that it is a climax to a most complete and successful life.

The point that I wish to emphasize, however, is that we should

apply this conception of life to ourselves, and see to it that we develop our bodies, minds and spirits at the proper time and in a consistent manner. There are no very definite lines of demarkation between these phases of life, less so perhaps with men than women, where the menstrual function, motherhood, etc., fixes fairly definitely certain periods. The probability, however, is that wide degrees of difference are quite normal with various types and races of people. In the same person, owing to a number of circumstances, both internal and external, there is probably also a wide range. Great variations in the number of years allotted to these different phases relative to each other are quite possible without any serious effect. If certain limits of time, however, are exceeded by one to the detriment of the other, abnormal conditions must result, which are bound to produce bad effects on the health, happiness and success of the individual concerned.

To illustrate my meaning, it is well known that it is detrimental to a young person's future life to sacrifice the time necessary for proper mental development too much to athletics, dancing and other bodily pleasures, which should occupy a secondary place and not interfere unduly with the vocation which has been undertaken. On the other hand, plunging into a mental development without a well-equipped body is a greater mistake. Wires can never be well adjusted without suitable poles placed to support them. Firm buildings cannot be erected without adequate foundations.

If the second phase of life—namely, the time devoted chiefly to mental growth—is protracted too far, the consequences may also be serious. A man who attempts to increase or continue his mental work at a time when his mind should be getting rid of its burdens will get a dubious result. A mental or physical breakdown will take place, or he becomes a business or professional failure. Should such a man live long enough (not usually the case) to reach an old age, there will be little spiritual development. The hard struggle, the reaction against sustained effort, the humiliation of failure, will produce a crabbed old age. He becomes miserly with his worldly goods, suspicious of his fellow-men, harsh in his judgments, a gossip, obscene often in his point of view, and with little thought of the sufferings of others.

Young women going out into the wide world in the active duties of nursing should regard these obvious successes or failures as sign-posts on the road of life. While you profit by the lessons they teach, at the same time cultivate the greatest tolerance for the lives of people in general. Who (in a developmental state themselves) can predict with certainty the ultimate success or failure of someone else? The frivilous young mother of the child you are called to attend, with whose love of pleasure you may not wholly sympathize, may nevertheless have within her being the possibility of great character development. Help her in the care of her

infant to the best of your ability and reserve your criticism. Remember always that the influence of a good woman is far-reaching, and the *good nurse* who is a good woman has a double advantage. Be tactful with the older relatives of your patients, who may often be very tiresome to you. They are apt to seek reasons for your conduct in a case, and possibly argue and debate your procedures and methods. Accept this in good faith, as part of the great game, cheerfully and reasonably. Should you occasionally run across one of those old failures in whom there is no spiritual trend, meet them with serenity and kindness, even though they may try maliciously to make you as unhappy and ill at ease as possible. You can win over even one of these in the eleventh hour. Work with enthusiasm and make the work of each day sufficient in itself. In this fact lies probably the greatest happiness, which is so beautifully exemplified in this quotation from the Sanscrit:

> "Listen to the exhortation of the dawn. Look to *this* day. For it is life—the very life of life.
>
> "In its brief course lie all the varieties and realities of your existence—the bliss of growth, the glory of action, the splendor of beauty.
>
> "For yesterday is but a dream and tomorrow is only a vision, but *today well lived* makes yesterday a dream of happiness and every tomorrow a vision of hope.
>
> "Look well, therefore, to *this day!*
> "Such is the salutation of the dawn."

If you are so fortunate as to meet in your professional vocations one of those rare old men or women who have reached the very fullness of life, a ripe old age, and who have normally developed their spiritual natures, have no fear of your relations with them. Medical work would be spared much that is irritating and disillusioning if all we contended with were as these. They will entertain and interest you and help you in many ways, although you cannot understand them, for who can comprehend "a peace which passeth all understanding"?

In conclusion, I would advise the very promising looking graduates I see here before me to apply the foregoing to their own careers. While you are young, develop your bodies and preserve a good physical condition indefinitely by taking plenty of outdoor exercise and various physical recreations and diversions. Marry if the right man present himself, but do not make this an object in your work. Develop your minds along normal channels and prepare for a time when you should stop all active duties. Put by something for a rainy day. I can wish you all nothing greater than that, after a successful and happy life, you will reach an age free from tears, where the approaching end of life is contemplated as its *fitting climax,* and not as an eternal tragedy.

INCISED WOUND OF HEART, SUTURE AND RECOVERY.

By Wm. J. Coleman, M.D.,
Medical Superintendent, University Hospital, Baltimore, Md.

THE following case is thought to be worthy of permanent record, and is reported for what it may be worth:

Patient after recovery from wound of heart.

On the evening of August 20, 1914, Jennie G., colored, female, aged 36, was admitted to the University Hospital. She had been slashed across the chest with a razor, and was in a very serious condition. She was taken at once to the operating-room, and ether was administered by the drop method. The anesthetic was well borne. The field of operation was cleansed by scrubbing with green soap. On inspection two wounds were seen on the left anterior chest wall; one 2 c. m. in length, 4 c. m. to left of mid-sternal line on a level with the left nipple, which was superficial in character. The second or main wound extended from a point below

and to the outer side of the first wound, across the left breast and thence to the angle of the scapula. This incision had evidently been made with a sharp instrument, and had severed all the integuments and muscles, and had opened the thoracic cavity through the fourth intercostal space. The lung was seen to be collapsed, and an opening 2 c. m. in length was seen in the pericardium. The two wounds mentioned were connected, bleeding checked with clamps and ligatures and 10 c. m. of the fifth rib was resected at its anterior end. The pericardium was opened sufficiently to inspect the heart, and a wound was found in the left ventricle. This was closed with three catgut interrupted sutures, and a cigarette drain was placed in the pericardial sac and the pericardium closed with catgut down to the drain. The left pleural cavity was cleansed by sponging and two cigarette drains introduced, and the muscles and integuments sutured with catgut and silk-worm gut. The patient withstood the operation well, and when placed in bed her pulse was 106 beats per minute.

Following operation the patient steadily improved, the highest temperature was 101, pulse 130 and respiration 36, soon falling to normal. There was some drainage from both the pericardial and pleural sacs for two weeks, and the wounds were completely healed in a month. She was discharged, well, on September 25, 1914.

Wounds of the heart do not occur in civil life with great frequency, but when they do occur, they are generally fatal. They may be the result of stabs or cuts or of gunshot injuries. Naturally, gunshot wounds are more fatal than stabs; but prompt surgical interference may save the sufferer from impending death in both varieties of wounds in about 50 per cent. of the cases reaching the operating table.

"Simon has collected (up to 1912) 241 operations for gunshot wounds, with 124 deaths (51 per cent. mortality), and 200 operations for stab wounds, with 99 deaths (49 per cent.)."—Astley Ashhurst's Principles and Practice of Surgery, 1914.

With these possibilities confronting us we should be prepared to extend to the heart the same treatment that has become recognized as essential in wounds of the abdominal viscera, namely, exposure and suture; and we shall have at least a considerable measure of success.

THE PHYSICIAN'S VISITING LIST. Lindsay and Blackiston's. For 1916. Sixty-fifth Year of Its Publication. Philadelphia: P. Blakiston's Son & Co. Leather, $1.25 net.

The character and scope of this visiting list is so well established that it is unnecessary for us to add anything save to say that the present edition is of the same nature as its predecessors and every whit as useful. It answers the purpose admirably for which it is designed, and physicians contemplating the purchase of a visiting list will be more than satisfied with it.

REPORT OF CASE OF STAB WOUND OF THE PERICARDIUM.

By Fred Rankin, A.M., M.D.,
Instructor in Surgery, University of Maryland.

THE first deliberate attempt at surgery of the heart was made by Callender in 1871, at which time a needle was removed from the myocardium. Roswell Park, in 1877, aspirated a myocardial abscess. Farina, in 1896, reported the first recorded case in which sutures were applied for a traumatic opening in the heart wall. In this case he used three silk sutures. The relatively rare occurrence of traumatic wounds of the pericardium and heart, which come to operation, perhaps warrants the report of a case, even though the outcome was unsuccessful.

On April 23, 1911, patient H. G., aged 35, laborer, was admitted to the surgical ward of the University Hospital from the accident room, with a history of having stabbed himself in the chest wall with a pair of scissors. Admission was at 7.30 P. M., the patient having stabbed himself a half hour previously. Practically nothing was known of the circumstances by the officers who accompanied him, hence an accurate history is unobtainable.

The examination showed a well-developed man, of average height, lying in dorsal decubitus position, and showing no signs of pain or *shock*.

The pupils react to light and accommodation. The expression of the eyes is dull and vacant. The patient persistently refused to answer questions. On examination of the chest in the seventh interspace one-half inch internal to anterior axillary line is noted a small stab wound about 2 c. m. in length, from which a small quantity of blood is oozing. Auscultation reveals nothing; the expansion is shallow, but equal on both sides. Percussion note on both sides is resonant. Heart sounds are distinct, but rather distant, probably due to an emphysematous condition of the chest. Pulse rate is 88, temperature 96° by axilla. Patient is not in condition of shock.

Two hours later I visited the ward and made the following note: "Within the past two hours the patient's condition has become rapidly and decidedly worse. At present he shows marked symptoms of internal hemorrhage. Pulse is small, compressible, running—rate, 138 to the minute. Heart sounds are very distant and indistinct, respiration 26, shallow and gasping. His dyspnea is his most distressing symptom. Pupils are dilated, abdomen is negative, and there is no vomiting. Stomach tube was passed, and a small amount of clear fluid withdrawn."

Chest.—Right front—negative. Left front—on percussion, a quadrangular area of dullness is made out, beginning at sixth interspace at sternal margin; thence to anterior axillary line in seventh interspace; thence to lower border of ninth rib in anterior axillary line, and thence over to seventh costosternal articulation.

A diagnosis of heart wound was ventured, and operation decided upon at once.

Operation.—Under ether anesthesia the chest was opened by a curved incision from the fourth to the seventh ribs. A musculocutaneous flap was dissected up and turned in toward the sternum, and portions of the sixth and seventh ribs, and their costal cartilages, were resected. Upon this exposure it was found that the wound had pierced the seventh costal cartilage, and opened the pericardium and pleura. In resecting the ribs I unintentionally enlarged the pleural wound. There was such an extravasation into the tissues that it was impossible to determine whether the internal mammary or one of the intercostal arteries had been primarily injured. I tied the internal mammary. The opening in the heart sac was now enlarged, and several ounces of clot, which filled it, thus impeding its action, were evacuated. A hurried examination of the heart itself failed to reveal a wound, but in the light of the subsequent outcome I may have overlooked an injury. However, the patient's condition was such that further interference seemed dangerous, and packing was put into the pericardial wound. No attempt was made at suturing it, and the patient was returned to the ward. In two days the packing was removed, and a smaller tuck was put in. There was a considerable drainage of sero-sanguinous fluid, but the patient's general condition seemed somewhat improved. Three days later the wound was discharging freely, and the discharge, becoming purulent, tubes were put into the chest. On the 9th day, while the chart was that of a distinct empyema, the drainage was good, and the patient's appetite and strength were returning in some slight measure. This picture continued until the 18th day, when the patient died suddenly—we thought of an embolus. Unfortunately, autopsy was denied, and the exact extent of his injury, as well as the immediate cause of death, was never determined.

Correspondence.

AMERICAN FIRST AID CONFERENCE.

Dr. Joseph C. Bloodgood, Secretary,
904 N. Charles Street.

BALTIMORE, MD., December 29, 1915.

AT the request of the American First Aid Conference, President Wilson has appointed a National Board of First Aid Standardization to deliberate carefully on first aid methods, packages and equipment, and instruction, and to recommend a standard for each to a subsequent session of the conference. The personnel of the board is as follows:

Dr. Richard H. Harte, chairman; representing the American Surgical Association, 1503 Spruce street, Philadelphia, Pa.

Assistant Surgeon-General W. C. Rucker, secretary; representing the Public Health Service, Washington, D. C.

Dr. J. Shelton Horsley, representing the American Medical Association, Richmond, Va.

Dr. John P. Kaster, representing the Association of Railroad Chief Surgeons; chief surgeon, Atchison, Topeka & Santa Fe Railroad, Topeka, Kans.

Dr. S. C. Plummer, representing the American Association of Railroad Surgeons; chief surgeon, Chicago, Rock Island & Pacific Railway, Chicago, Ill.

Major Robert U. Patterson, representing the United States Army Medical Corps and the American Red Cross; Department of First Aid, Red Cross, Washington, D. C.

Col. Louis A. La Garde, U. S. A., retired; representing the War Department, Washington, D. C.

Surgeon A. M. Fauntleroy, representing the Navy Department, Washington, D. C.

To attain the objects of this movement it is essential that the board should consult the best opinion of the country on the problems involved and should enlist the sympathy and active co-operation of the medical societies. To this end a questionnaire on first aid has been sent out to the surgeons of railroads, mines, factories and physicians in industrial practice. A large number of replies have already been received. The principal National and State medical societies have been invited to appoint special first aid committees of three members each to co-operate with the Board of Standardization. The following are among those committees already appointed:

The American Surgical Association—Dr. Edward Martin of Philadelphia, Pa.; Dr. Emmet Rixford of San Francisco, Cal.; Dr. John Bapst Blake of Boston, Mass.

The American Medical Association (Surgical Section)—Dr. F. B. Lund of Boston, Mass.; Dr. J. F. Mitchell of Washington, D. C.; Dr. J. M. Wainwright of Scranton, Pa.

The Southern States Association of Railroad Surgeons—Dr. Southgate Leigh of Norfolk, Va.; Dr. Bacon Saunders of Fort Worth, Tex.; Dr. Ambrose McCoy of Jackson, Tenn.

Conference of Physicians in Industrial Practice—Dr. John J. Moorhead, New York city; Dr. W. Irving Clark, Worcester, Mass.; Magnus W. Alexander, West Lynn, Mass.

Medical Society of the District of Columbia—Dr. Charles S. White, Washington, D. C.; Dr. William P. Reeves, Washington, D. C.; Dr. H. H. Kerr, Washington, D. C.

Utah State Medical Association—Dr. R. S. Joyce, Ogden, Utah; Dr. J. F. Critchlow, Salt Lake, Utah; Dr. J. W. Aird, Provo, Utah.

Summary of Results of Examination Held by the Board of Medical Examiners of Maryland, December 14, 15, 16 and 17, 1915.

No.	College of Graduation.	Anatomy	Surgery	Pathology	Obstetrics	Practice	Chemistry	Materia Medica	Therapeutics	Physiology	Total	Average
1	University of Maryland, '15	87	84	88	86	94	85	96	87	92	799	89
2	Medical College of Virginia, '14	75	..	61	..	87	58	..	..	..	...	..
3	Johns Hopkins, '15	85	87	91	90	95	90	53	75	80	746	83
4	University of Maryland, '15	75	87	78	85	82	98	75	100	93	773	86
5	University of Maryland, '11	65	65	75	68	77	75	81	91	78	675	75
6	Medical College of Virginia, '15	55	87	63	73	77	32	80	75	75	617	68
7	Chicago College of Medicine and Surgery, '15.	50	79	70	78	81	61	76	79	65	639	71
8	College Physicians and Surgs., Balto., '15	77	93	90	93	91	78	92	85	95	794	88
9	College Physicians and Surgs., Balto., '15	61	82	81	77	67	70	95	82	85	700	78
10	Chicago College of Medicine and Surgery	75	..	..	..	..	60	..	..	..	...	..
11	Howard University, '14	84	68	76	71	75	90	81	89	78	712	79
12	Harvard Medical, Boston, '15	85	90	95	93	96	100	95	94	97	845	94
13	Maryland Medical College, '13	23	..	75	..	..	25	..	..	55	...	..
14	College Physicians and Surgs., Balto., '15	86	83	93	80	92	87	95	88	95	799	89
15	College Physicians and Surgs., Balto	75	..	..	..	..	60	70	..	75	...	..
16	Maryland Medical College, '13	..	..	75	..	..	..	..	..	..	...	..
17	University of Maryland, '15	55	80	78	85	80	39	80	75	78	650	72
18	College Physicians and Surgs., Balto., '14	..	64	69	..	..	..	..	..	..	...	..
19	University of Maryland, '15	75	89	69	87	85	75	79	80	65	704	78
20	College Physicians and Surgs., Balto., '15	67	89	73	85	57	30	80	87	68	636	71
21	University of Maryland, '15	53	83	75	85	68	50	70	68	69	621	69
22	University of Maryland	50	..	..	..	..	65	86	..	77	...	..
23	University of Maryland, '15	75	82	85	85	75	70	75	85	79	711	79
24	National Medical College, Mexico, '03	77	78	72	59	42	35	30	66	49	508	56
25	Maryland Medical College, '12	62	..	59	..	64	..	..	..	..	...	..
26	University of Maryland, '15	82	81	78	81	94	80	92	79	95	762	85
27	Maryland Medical College, '13	55	49	39	63	44	85	77	80	49	541	60
28	University of Maryland, '15	67	82	75	86	82	65	86	76	89	708	79
29	Temple University, '15	75	79	68	90	93	45	81	79	81	691	77
30	University of Maryland, '14	83	74	90	84	79	70	88	83	94	745	83
31	College Physicians and Surgs., Balto., '15	65	88	90	96	75	50	80	61	87	692	77
32	University of Missouri	95	..	..	..	..	100	91	..	87	...	..
33	Johns Hopkins, '15	89	89	90	84	90	95	96	93	98	824	91
34	University of Maryland, '14	88	86	89	80	89	80	96	96	98	802	89
35	Johns Hopkins, '14	81	74	89	74	77	85	88	89	88	745	83
36	Howard University, '15	82	90	90	94	83	100	85	98	90	812	90
37	University of Maryland, '15	75	82	78	76	79	50	89	82	82	693	77
38	Medico-Chirurgical, Philadelphia, '15	Failed to appear.										
39	University of Maryland	75	..	..	..	..	75	84	..	83	...	..
40	Maryland Medical College, '10	Failed to appear.										
41	Howard University, '14	81	75	81	91	76	65	83	80	79	711	79
42	University of Maryland, '14	75	..	75	88	..	..	..	..	75	...	..
43	University of Louisville, '12	65	..	..	..	..	45	..	..	..	...	..
44	Johns Hopkins	84	..	..	..	..	78	83	..	82	...	..
45	Johns Hopkins, '15	86	90	91	80	88	90	88	90	83	786	87
46	College Physicians and Surgs., Balto., '14	..	..	72	..	..	50	..	88	76	...	..
47	College Physicians and Surgs., Balto., '13	81	90	76	90	87	85	72	89	97	767	85
48	University of Maryland, '15	..	..	80	87	..	80	82	75	..	...	..
49	University of Virginia, '14	83	88	94	76	75	80	90	100	100	786	87
50	Johns Hopkins, '15	84	86	78	73	89	90	88	75	93	756	84
51	Bennett Medical College, '14	45	..	71	..	58	10	..	..	..	...	..
52	University of Maryland, '15	49	75	75	75	57	45	81	78	75	610	68
53	College Physicians and Surgs., Balto., '15	81	74	75	81	75	63	87	87	98	721	80

In the above summary an average of 75 is required of those participating in the examination for the first time in order to secure a license. Those who have failed are eligible to re-examination at the expiration of six months. They are then obliged to receive a rating of 75 in each branch in which they are re-examined before license can be issued. Under the Maryland laws, students who, at the end of their second year, have successfully passed their college examination in Anatomy, Chemistry, Materia Medica and Physiology, are entitled to examination by the Board of Medical Examiners in these branches. The ratings made by these students in the examination known as the "second-year examination" are carried forward and made part of the final examination, when an average of 75 must be obtained to secure a license. We trust that this statement will make clear the apparently incomplete examination of certain participants.

REPORT OF BOARD OF MEDICAL EXAMINERS OF MARYLAND.

QUESTIONS AT THE DECEMBER (1915) EXAMINATIONS.

ANATOMY.

1. Describe upper third of humerus, including attachments of muscles.

2. Describe the temporo-maxillary articulation.

3. Describe the internal jugular vein.

4. Describe the lachrymal apparatus.

5. Describe the renal blood circulation.

6. Describe the pyloric orifice of the stomach.

7. Locate and describe Peyer's glands.

8. Give origin, insertion and nerve supply of following muscles: Rectus abdominalis, masseter, gluteus maximus and plantaris.

9. What is composition of intervertebral dises? How much of spinal column is formed by these dises?

10. Superficial and deep origin, course and distribution of the eighth nerve.

THERAPEUTICS.

1. Give the physiological action and therapy of sulphonal.

2. Give the physiological action and therapy of strophanthus.

3. State the medicinal and dietetic uses of saccharum.

4. Give the indications and the contraindications for the use of chloride of sodium.

5. Write a prescription in Latin, without abbreviation, containing four ingredients, one of which is tartras antimonii et potasssii, stating condition for which it is to be used, with directions for administration.

6. Give the therapy of kali iodide and best method of administration.

7. Define and illustrate pharmaceutical and chemical incompatibility.

8. What similarity is there between morphia and apomorphia? Give the therapy of the latter, how preferably administered and for what special purpose.

9. Urotropin, its therapy?

10. Guiacol, therapy and prescribe form of administration.

MATERIA MEDICA.

1. (a) Tetanus antitoxin. Its preparation and dose. (b) Dicuss typhoid vaccine with reference to its preparation, doses and administration.

2. (a) Write a prescription containing nitrate of silver to be used in infant's eye. (b) Write a prescription for ten powders for a child two years old. The prescription to contain calomel, soda bicarb. and ipecac

3. Digitalis. Its preparations and doses and incompatibles.

4. What is an alkaloid? Name the alkaloids of nux vomica and give average dose of each for an adult.

5. (a) Give a rule for the calculation of the average dose of medicine for a child based upon a given dose for an adult. Give example for a child four years old. (b) State also what circumstances modify the effect of drugs.

6. Define and give examples of the following classes of drugs: Mydriatics, myotics, emmenagogues, and hemostatics.

7. Give source of opium, quinine, iodine and pepsin.

8. Sodium. The official preparations and doses.

9. Name some of the general classes into which medicines are divided and give two examples of each.

10. Give the average adult dose of salol, salicylate of sodium, tincture of aconite, Fowler's solution of arsenic and Donovan's solution.

PHYSIOLOGY.

1. (a) Describe the origin of the various constituents of the blood. (b) Where are the red corpuscles of the blood supposed to be destroyed? (c) How do the white corpuscles compare in number with the red? (d) Give some of the causes for an increase or decrease of the white corpuscles.

2. (a) What is meant by the pulse? (b) What three factors are concerned in the production of the pulse? (c) What conditions may alter the pulse rate?

3. (a) What post-mortem test should be applied to prove that air has entered the lung of a supposedly stillborn child? (b) Give method of producing artificial respiration.

4. Describe the digestion, absorption and disposition of fats.

5. (a) Of what does the nervous system consist? (b) Describe the reflex and automatic action of the nervous centers.

6. Discuss the difference between cold-blooded and warm-blooded animals.

7. Describe ovulation.

8. Describe succus entericus.

9. State what changes take place in the air in respiration.

10. What are the requirements of a normal diet?

PATHOLOGY.

1. What is diphtheria antitoxin? How made?

2. What is anti-typhoid vaccine? How made?

3. Contrast the reactions of the above-mentioned agents when used.

4. Trace the development of acute general miliary tuberculosis.

5. Describe the process of resolution in lobar pneumonia.

6. Tell what you know of cerebral embolism. Its causes and effects.

7. Why and when does a lymph node adjacent to an infected area become swollen and painful?

8. Give the morbid anatomy of an irritable anal ulcer.

9. Describe the changes occurring in the knee in a case of acute traumatic synovitis.

10. Describe the changes that occur in a case of freezing; for instance, a frozen foot.

PRACTICE OF MEDICINE.

1. Give symptoms and treatment of multiple sclerosis.

2. Define: (a) Kernig's sign. (b) State what disease it ocurs in and what symptoms would lead you to suspect the existence of this sign. (c) Ulcerative stomatitis. State what remedy is the specific for this disease.

3. Define: (a) Landry's paralysis (b) State what marked symptoms accompany this disease and what is the prognosis. (c) Dysphagia. Name some diseases in which it occurs.

4. Differentiate: (a) Tonic and clonic spasms. (b) Sibilant and sonorous rales. (c) Define Babinski's sign. In what diseases does it occur?

5. Differentiate follicular tonsilitis and diphtheria.

6. Name day of eruption in smallpox, chicken-pox, measles and scarlet fever.

7. Being called to see a case of pulmonary tuberculosis in its early stages, by what symptoms would you diagnose the case and what measures would you employ?

8. Give diagnosis of pellagra and treatment of same.

9. Differentiate hepatic, intestinal and renal colic.

10. Give prophylactic treatment of wounds which might lead to tetanus and give treatment of same if it does develop.

SURGERY.

1. Name the various forms of plastic iritis. Give symptoms and treatment of one form.

2. What inflammatory conditions may arise in the right iliac region, with symptoms of each.

3. Give symptoms, diagnosis and treatment of tuberculous disease of the hip joint.

4. What surgical conditions occur in the neck? Give symptoms and diagnosis of the commonest form.

5. Name the varieties of fracture about the elbow joint. How would you treat them and why?

6. What are the causes and symptoms of intestinal obstruction?

7. Give symptoms, diagnosis and treatment of carcinoma of the rectum.

8. What are the indications for removal of the mammary gland?

9. Give symptoms, diagnosis and treatment of stone in the kidney. What is Dietl's crisis?

10. Called to attend a patient who is suffering from a troublesome epistaxis, describe the methods you would pursue to check it.

OBSTETRICS

1. Give diagnosis and treatment of placenta prævia at term.

2. Describe three methods of resuscitating a child born in a state of asphyxia.

3. Give the Wiegand-Martin method of delivering the head in a breech presentation.

4. Describe fully how you care for a child from the moment it is born until the cord is cut.

5. Give signs and symptoms of fetal death.

6. Give treatment of uterine inertia.

7. Give Crede's method of preventing ophthalmia neonatorum.

8. How would you check a severe hemorrhage immediately after delivery of the placenta?

9. Describe accurately how you would do a curettement.

10. Give differential diagnosis between sapremia and septicemia in puerperal fever.

CHEMISTRY.

1. Mention two examples of the following classes of elements: Univalent, bivalent, quadrivalent.

2. Describe two methods of obtaining hydrogen.

3. Distinguish between sulphides, sulphates and sulphites.

4. What are the allotropic modifications of sulphur?

5. What two oxides of phosphorus are known? Give formulæ.

6. What is a simple and what is a compound ether?

7. What atomic group is characteristic of the organic acids and what is it called?

8. What form of sugar sometimes occurs in urine? How is it detected and estimated quantitatively?

9. What is acetone and what is diacetic acid? How are they detected in urine?

10. Describe method of testing for blood in the stomach or intestinal contents.

MARYLAND MEDICAL JOURNAL

NATHAN WINSLOW, M.D., *Editor.*

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BALTIMORE, FEBRUARY, 1916

DIET IN NEPHRITIS.

DURING the past few years there has been a craze permeating the internist in the treatment of nephritis by diet. It seems that with every new suggestion in medicine the innovation is for a time being run into the ground. Thus, at one time, when a woman's abdomen was opened, her ovaries, if a little bit diseased, were removed without the least thought of the consequences resulting therefrom. And now for some few years there has been a wild route of the surgical end of the profession to plate fracture. Thus it has been, and possibly ever will be, both in medicine and surgery a sort of blind follow my leader. In nephritis this has taken the form of dieting, especially the limiting of the protein intake. Doubtlessly in some instances, more from blind luck than from scientific grounds, patients suffering from this or that form of nephritis have been benefitted by dieting. However, in nephritis, as in other conditions affecting the human engine, the physician should look upon the individual as a case unto himself, rather than an example of a group. Here as elsewhere the old maxim applies, "What is food for one, is poison for another." No hard and fast lines can be laid down, no stereotyped treatment is available, but only after careful consideration and painstaking investigation is the physician justified in outlining the dietary of these patients. Cadis Phipps of Boston is undoubtedly on the right tack when he states, in the *Boston Medical and Surgical Journal*, that we have fallen perhaps too much into the habit of thinking of diet in terms of calories, forgetting the variations and idiosyncrasies of different individuals. Indeed, we are too much impressed with the dis-

ease and so neglect the patient. And also, with all our precision, it is well to hesitate and stop, as it may be that our system of dietetics is but half the truth, and that further research will change many of its apparently basic principles. Upon the surface one would suppose that a kidney getting rid of a very small amount of protein should be fed no more than the kidney is caring for. Investigators at first worked upon this principle, but after some success and some failure, came justly to the conclusions that there were other forces at play than the kidney, that in some instances the limiting of the protein intake to the amount of protein elimination did not succeed in benefitting the condition of the patient. So they were forced to the conclusion that vital forces are different from mechanical forces, and that there is no rule applicable to every nephritic when it comes to limiting this or that element of the dietary. Without being able to explain they have been forced to the conclusion that in some cases of protein retention it is better not to limit the proteid intake too strictly, else the patient will go to pieces. Doctor C. W. McElfresh of Baltimore has done a great amount of pioneer work in diet in nephritis. In the beginning of his investigations, which have now extended over a period of more than five years, he paid rigid attention to the number of calories allowed nephritics, also the kind and quantity of food permitted. Gradually he has come to the conviction that too much attention must not be paid to the nitrogen retention. By limiting the protein ingestion in some cases he has noted remarkable improvement in the health of the patient, but other patients with the same general plan of treatment have failed to respond. In this class of nephritics he has found that by allowing a more liberal protein diet produces better results. His experience substantiates that of Phipps, namely, that any rigorous system of diet may, but should not, be so strict or continued so long that it may be distinctly harmful to the individual case. In his hands, as in Phipps, more freedom in the allowance of protein than is recommended in the text-book nephritic diet may be of great advantage in the individual case. Therefore we are forced to the conclusion that modern investigators are on the right path in treating nephritis principally by taking the load off the kidney by proper dieting; we are also of the opinion that much more work must be done before dieting in nephritics has been placed on a sound basis.

Medical Items.

Dr. Arthur de Talma Valk, formerly of Annapolis, Md., is a member of the surgical staff of the Twin City Hospital, Winston-Salem, North Carolina.

Dr. Roy D. McClure, resident surgeon at Johns Hopkins Hospital, and once associated with Dr. Alexis Carrel, surgeon, has been made surgeon-in-chief to the new Henry Ford Hospital, in Detroit. He will leave Baltimore about March 1.

Dr. McClure's appointment makes the second from the Hopkins staff to the Detroit institution in the last two months. Dr. Frederick Janney Smith, assistant resident physician at Hopkins, was appointed in November as physician-in-chief at the Ford Hospital. About a year ago three other Hopkins men were named for positions on the staff, and Dr. Frank J. Sladen as advisor to Mr. Ford.

Dr. William H. Bash, accident physician of Mercy Hospital, has been reappointed. He has served more than a year in that capacity at the hospital, and, according to his associates, has made an enviable record. He recently resigned, but was prevailed upon to return to his old place.

Dr. William H. Welch of the faculty of the Johns Hopkins University arrived in Baltimore on January 5, after a six months' trip to the Orient. He sailed from Shanghai December 11.

Dr. Karl H. Van Norman, formerly of the staff of the Johns Hopkins Hospital, and now a captain in the Royal Canadian Army Medical Corps, is in charge of a British hospital division at Ramsgate, England. There are 600 beds in the hospital, and Dr. Van Norman has medical supervision of over 125 patients, all war victims.

Dr. C. Reid Edwards has been appointed superintendent and Dr. Louis A. Buie resident surgeon of the Kernan Home for Crippled Children.

Dr. Charles A. Overman, who has been ill at the University Hospital for several months, is reported to be convalescent.

Two important changes in the hospital staff of the Johns Hopkins Hospital have been announced. The resignation of Dr. Leonard G. Rowntree, associate professor of medicine, was accepted, and the appointment of Dr. Lysander P. Holmes of the Health Department of New York City as third assistant superintendent was given out. Dr. Rowntree has been appointed professor of medicine at the University of Minnesota. The appointment of Dr. Holmes is to fill the vacancy which was caused by the resignation of Dr. Karl H. Van Norman, first assistant superintendent, about two months ago. Dr. Ralph B. Seem, second assistant, was promoted to Dr. Van Norman's position, and Dr. Lewis A. Sexton, third assistant, was put in Dr. Seem's place. Dr. Holmes comes from the Riverside Hospital, North Brother's Island, New York, which is operated by the Health Department of New York.

In a struggle recently with a violently insane patient, Dr. William J. Coleman, superintendent of the University Hospital, fractured and dislocated his finger.

Dr. Martin F. Sloan, medical superintendent of the Eudowood Sanatorium at Towson, has returned from a trip to California and through the South.

Dr. William J. Todd, who has been medical advisor to both the faculty and students of Mt. St. Agnes' College at Mt. Washington for the past 25 years, has been presented with a silver chocolate service.

Dr. Christopher C. Wingo celebrated his ninety-second birthday recently at his home in Baltimore.

Dr. Charles E. Fox, who was formerly connected with the Maryland State Board of Health, concerning whose welfare in Serbia there were many rumors, is safe in Uskub, where he is a member of the American Sanitary Commission that left Saloniki, Greece, after completing a campaign against typhus.

The American Orthopedic Association announces the appointment of Dr. Mark H. Rogers, Boston, as editor of *The American Journal of Orthopedic Surgery*, the only periodical in the English language devoted to orthopedics. This journal, which has now completed 13 volumes as a quarterly publication, will henceforth be issued monthly, the first number in the new form being that of January, 1916.

The office of publication has been transferred

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The annual meeting of the Anne Arundel County Medical Society was held at the Emergency Hospital, Annapolis, Md., January 11, 1916. The following officers were elected for the ensuing year:

President—Dr. Charles R. Winterson, Hanover, Md.

Vice-President—Dr. J. Oliver Purvis, Annapolis, Md.

Treasurer—Dr. Frank H. Thompson, Annapolis, Md.

Delegate to the Medical and Chirurgical Faculty of Maryland, State Society—Dr. Thomas H. Brayshaw, Glenburnie, Md.

Alternate Delegate—Dr. James J. Murphy, Annapolis, Md.

Clinical cases were reported by Drs. Brayshaw, Purvis and Winterson and discussed by all present. Dr. Thomas P. Benson of Elkridge, Md., read a paper on "Angina Pectoris."

Those present were the following: Drs. Charles R. Winterson, Thomas H. Brayshaw, Thomas P. Benson, John Collinson, J. Oliver Purvis, S. S. Hepburn, Frank H. Thompson and Frances E. Weitzman.

BIRTHS.

Recently, to Wilbur M. Scott, M.D., University of Maryland Medical School, '12, and Mrs. Scott, of Devereaux, Ga., a daughter.

MARRIAGES.

Harry Aloysius Bishop, M.D., University of Maryland Medical School, '12, of Washington, D. C., to Miss Roberta Carson Morgan Jones of Fort H. G. Wright, New York, at Fort H. G. Wright, October 6, 1915. Dr. and Mrs. Bishop will reside at 1430 Rhode Island avenue, Washington, D. C.

David Silberman, M.D., University of Maryland Medical School, '12, to Miss Jennie Merowitz, both of Baltimore, Md., at Baltimore. January 4, 1916. Dr. and Mrs. Silberman will reside at 1729 Linden avenue.

DEATHS.

James Walter Baird, M.D., College of Physicians and Surgeons, '74, of Surry county, Virginia, died at his home near Waverly, Va., November 30, 1915, from the effects of a gunshot wound of the head believed to have been self-inflicted, aged 65 years.

Albert Augustus Lindabury, M.D., Baltimore Medical College, '86; Hahnemann Medical College, Philadelphia, '90, of Scranton, Pa., died in the Scranton State Hospital November 22, 1915, from diabetes, aged 53 years.

Josiah Lee McComas, M.D., University of Maryland Medical School,, '58, pioneer physician of Oakland, Md.; acting assistant surgeon United States Army throughout the Civil War; a founder and vice-president of the Pan-American Medical Congress; health officer of Garrett county, Maryland, and local surgeon at Oakland for the Baltimore & Ohio System for many years, died at the home of his son in Oakland, Md., December 20, 1915, aged 80 years.

William Philip Spratling, M.D., College of Physicians and Surgeons, '86; from 1894 to 1908 medical superintendent of the Craig Colony for Epileptics, Sonyea, N. Y., and later a practitioner of Baltimore, and professor of physiology and nervous diseases in the College of Physicians and Surgeons, Baltimore, from 1908 to 1909; formerly president of the National Association for the Study of Epilepsy; author of a work on "Epilepsy and Its Treatment"; for the last four years a resident of Welaka, Fla., died in that place December 22, 1915, from the effects of a gunshot wound accidentally self-inflicted while hunting, aged 52 years.

Joseph A. Miles, M.D., College of Physicians and Surgeons, '07, of Baltimore, Md., died in the Mercy Hospital, from tuberculosis, December 14, 1915, aged 43 years.

James E. Gauline, M.D. (license, Maryland), for more than 22 years connected with the Home Friendless Society, Waverly, Baltimore, died at his home in that place, from cerebral hemorrhage, December 3, 1915.

James Garrett Linthicum, M.D., University of Maryland Medical School, '59; formerly professor of the practice of medicine in the Baltimore University; a member of the Baltimore City Council for four terms, died at his home in West Baltimore, from pneumonia, December 7, 1915, aged 81 years.

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EDITORIAL SIDELIGHTS ON THE EUROPEAN SITUATION.

The Medical Times.

It may seem a trifle incongruous to calmly write on ordinary medical matters in Europe when the entire world is so stirred by the European war. We feel, however, that people are so surfeited by such an amount of martial news that it may be restful to consider some phases of European medicine in vogue before the outbreak of hostilities. We had hoped to carefully investigate the spas of France and Germany, but as fate gave us the opportunity of witnessing the mobilization of four great armies, we were able to make only cursory examinations, and we must confine our writings in this connection to limited confines.

France boasts three bathing resorts of world-wide reputation—Vichy, Aix-les-Bains and Evian-les-Bains on Lake Geneva. The first is too well known to need description, and we will consider Aix, a place made especially well known to Americans by the great interest displayed in it by the late J. Pierpont Morgan.

Aix-les-Bains is eight hours south of Paris, and has been famous for its baths since the days of the Romans. There are still to be seen the Roman baths, a temple to Diana and the Arch of Campanus. The city is picturesquely situated between two ranges of the Savoie Alps. Directly behind it loom the mountains. On Mt. Revard, reached by a cogwheel road, is an observatory 2000 feet above sea-level, from which on a clear day we are told Chamonix and Mt. Blanc can be seen. To the south the mountains were covered with their eternal mantle of snow, and in July resembled our Rockies in January. A crowning feature of Aix-les-Bains is its beautiful lake, Lac du Bourget, which adds the final touch to a charming scene.

The city has about 40,000 inhabitants, and is a typical French town, with its two casinos, theaters, fine hotels, shaded, tarred streets which know not dust, fairy-like gardens, in which the fragrant cyclamen is so noticeable, and parks, walks and drives.

Aix has five hospitals. One, the Leon Blanc, named after the chief physician at the baths, was built and equipped by the late Mr. Morgan, who annually took the cure at Aix under Dr. Blanc. He also contributed largely to the erection of the Municipal Hospital.

The center of interest of Aix-les-Bains is the baths, and that means the bathing establishment, L'Etablissement Thermal, a palatial-looking building resting on the lowest buttresses of Mount Revard. Two hot springs give the place its cause for fame. The sulphur spring opens in the establishment, and the other, an alum spring, is 100 yards away. The two seem to have a common origin, we were informed by Dr. A. Goddard, one of the leading physicians of the establishment, and to whom we are indebted for many courtesies, including much of the data given herewith. The water is the most radio-active of France, and the two springs produce 1,000,000 gallons every 24 hours. In addition, there opens in the establishment a cold spring of 500,000 gallons capacity.

The Establishment has a staff of 30 physicians and 200 masseurs and masseuses. The foundation stone was laid in 1776 by King Amedee of Savoie, and the structure consists of two stories and a basement. It has 46 douche (bath) rooms, 7 local douche rooms, 16 vapor bathrooms, three hydrotherapeutic rooms with plunge, 6

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swimming pools, 37 baths and numerous other rooms for treatment. Every hydrotherapeutic method known to science is employed there.

For internal treatment, the water from three other springs is utilized, as by composition they are especially indicated for cases handled in the Establishment, which are: Chronic articular and atonic gout; rheumatic gout; sciatica and lumbago; chronic rheumatism, sequelæ of acute and subacute articular rheumatism; sequelæ of infective and pseudo-rheumatic (gonorrhœal) arthritis, including certain forms of tuberculous rheumatism; joint affections of traumatic origin; the sequelæ of acute arthritis; hydarthrosis with stiffness or commencing ankylosis; periarthritis; arthrosynovitis and tendinous synovitis consequent upon dislocations, fractures and operations; neuralgia of diathetic origin or a *frigore:* sciatica, cervicobrachial neuritis; professional cramps, peripheral neuritis of alcoholic origin and otherwise; intensive treatment of syphilis.

Among the secondary indications taken are polyarthritis deformans in its early stages; sequelæ of hemiplegia, spinal paralysis; locomotor ataxia at a stage where specific treatment is indicated, and sequelæ of phlebitis with hard œdema and functional impotency of limb owing to stiffness of joint and muscles. Acute inflammatory joint conditions and cardiorenal conditions are not accepted.

The question is asked: How is spa treatment carried out? At Aix the thermal treatment is usually taken in the forenoon. The patient is taken from his bed by two porters, who convey him in a closed sedan chair to the Establishment. There he receives the hydro-mineral treatment prescribed by his medical adviser: douche massage, sweating, vapor baths, various douches and baths.

The *Aix-les-Bains douche*, or *douche-massage* is administered by masseurs or masseuses. The whole body is massaged, kneaded and rubbed, the patient being meanwhile deluged with a torrent of hot mineral water. This under-water massage usually lasts from eight to 10 minutes, after which the patient is placed in one corner of the bathroom and is given a direct douche from the hose, the pressure and temperature of which are regulated in accordance by the physician. The patient is then wiped dry, after which he dresses and goes for a brisk walk or rests for an hour, or is wrapped in a flannel peignoir and blankets and taken back to bed, where the sweating, initiated in the bath, is allowed to continue for a variable period according to circumstances.

The vapor baths are given in the "bouillons," which are small rooms communicating with those in which the douche-massage is administered. A shower of hot mineral water falls continuously, and as it strikes the floor from a height it produces a sort of hot mist with which the room is filled, at a temperature of about 110 degrees F. Patients who are required to perspire remain there for from 4 to 20 minutes, either before or after the douche-massage.

In the Berthollet department the vapor baths are either local or general. The effect is produced by a curent of hot moist air obtained by allowing the hot mineral water to fall from a height onto a stone basin, whence the water escapes, but the hot, moist air passes into a large box when intended for general sudation, or into a special drum if for local application. For general sudation

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the patient is seated in a box which is closed except for an aperture for the head to pass through, the whole body being thus plunged in a hot moist atmosphere. For local application the limb is placed in a specially devised apparatus, which allows the hot air to play only on the desired part. The part is often massaged after the vapor bath. This same current of hot sulphurous vapor is employed for inhalation. The baths, properly so called, are given either with pure hot mineral water that has been allowed to cool, the so-called "bains refrigédés" or with the hot mineral water cooled by the addition of cold water. The "submarine" and vaginal douches are always administered at the natural temperature of the mineral water, the patient lying in a bath at an average temperature of 35 degrees C. (95 degrees F.).

In addition to the Establishment there is the Marlioz Establishment, which is devoted to the treatment of chronic diseases of the respiratory organs, such as simple chronic rhinitis, atrophic rhinitis, naso-pharyngeal catarrh, granular pharyngitis, chronic dry pharyngitis, chronic tracheo-bronchitis and catarrh of the larger bronchi, as well as acute blepharitis, chronic conjunctivitis, etc.

Another institution of world reputation in Aix-les-Bains is the Zander Institute, a physio therapeutic institution, under the direction of Dr. Guyenot, who is well-known to American physicians, on account of visits to our medical centers. He is especially interested in electrotherapeutics and in skiagraphy. The institute is completely equipped for mechanotherapy. It has in addition rooms for medicated and carbogaseous baths, Fisher & Kiefer system (Nauheim baths); skiagraphy, radioscopy and radiotherapy; for radiant heat and light baths (dowsing, both local and general), blue light for electrodiagnosis, for electrotherapeutic applications, as faradic, galvanic, undulatory, sinusoidal, static electricity, high frequency (arsonvalization), discharge of condensers, Leduc currents, Morton currents, iosonization, etc., and for vibratory massage. There is a special department for mineral water sprays with patent appliances yielding an integral spray of the mineral water at any temperature and pressure without the intervention of steam and a department for radium emanations, allowing its use in baths so that patients can drink or inhale water laden with radium emanation in definite amount.

The German spas have world-wide reputations. On our itinerary were Baden-Baden, Bad-Nauheim, Wiesbaden, Marienbad and Homburg. The first named, beautifully situated in the Black Forest, is too well known to necessitate a description in limited space. Bad-Nauheim is 25 miles from Frankfort on a slope of Johannisberg in the Taunus Mountains. This beautiful resort is best known for the treatment of cardiac conditions. The waters owe their efficacy to the graduated temperature employed, the carbonic acid gas, salts of calcium and magnesium, and to their radio-activity. The baths are given in increasing strength throughout the series, gas and mineral salts being added to the successive sets which comprise it.

The most ancient and possibly the best known of the German spas is Wiesbaden, the history of which goes back to the early days of the Christian era. It is now a beautifully laid out city of 120,000 people, with wide, shaded streets, spacious houses, fine public buildings and a great kurhaus which is situated in a charming park, the Kurplatz. The kurhaus is really a great casino.

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Coffee is served on the veranda in the afternoon and crowds gather to sip fragrant *café naturel* and listen to the music of an excellent orchestra. At the leading thermal resort is a *Kochbrunnen,* or hot spring. The water resembles weak chicken broth in taste and looks, and contains considerable iron and some sulphur. Up to 40 years ago Wiesbaden was famous for its gambling, but now it is a resort and cure alone, and as such it attracts about a quarter of a million people annually.

Another fashionable and largely patronized spa is Homburg, also in the Taunus Mountains. It has eight salt springs, which are particularly efficacious in the treatment of diseases of the gastro-intestinal tract. Gout and rheumatism are said to succumb after bathing sufficiently in the waters.

Homburg, though smaller than Wiesbaden, is delightfully situated, and its parks, gardens and drives make it a much-sought-after resort.

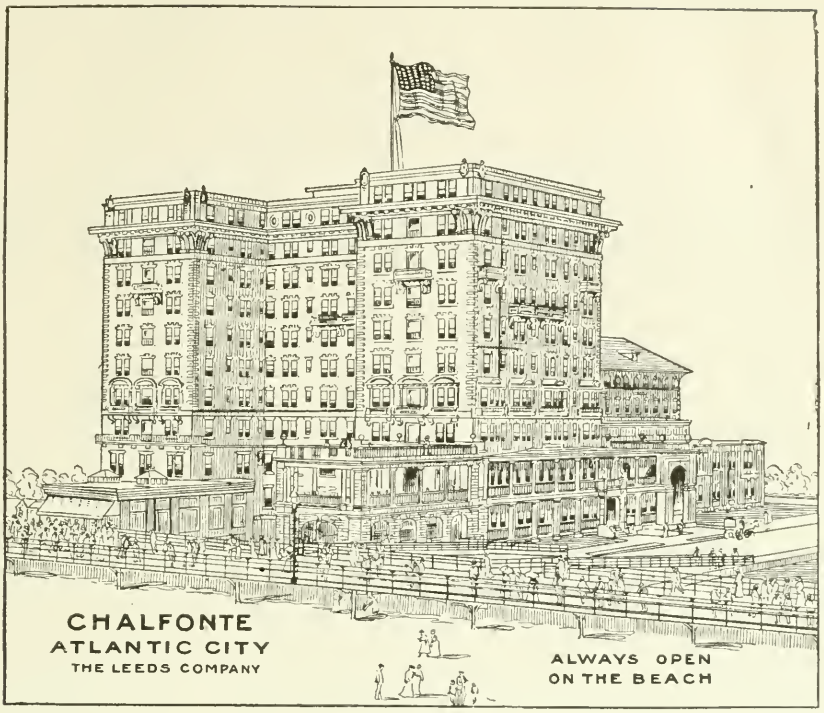
What the result of the war will be on the bathing resorts depends largely on the outcome of hostilities. Certain it is, however, that many Americans who annually visit French, German and Austrian spas will not do so next summer, and Saratoga Springs, N. Y., will benefit in consequence. These famous springs, now owned by the State of New York, offer full opportunity for baths and courses of treatment for all the diseases which are treated at the European resorts. It was to insure the maintenance of the springs of Saratoga and make them available to the greatest number of people that the State took over the property.

Dr. A. W. Ferris, the director of the springs, says: "At Saratoga Springs facilities exist comparable with those at Nauheim. It occupies a central position on a plateau about 25 miles square, averaging 400 feet above sea level in the village and its neighborhood. The soil is sandy loam, clay, sand or glacial drift, and is in general very porous. There is a large proportion of sunny days and the sky has the blue of the open country. The air is unusually fresh, dry and tonic. The Saraghtoghie (Nauheim) baths draw water from Hathorn No. 1 spring. The specific gravity of the water runs from 1.010 to 1.020, with a total of 8,414.73 milligrams per liter of solids in solution, of which 2288.92 milligrams represent the calcium salts, and 1335.59 milligrams represent the magnesium salts, while the various chlorides total 4217.78 milligrams per liter.

"The CO_2 content naturally varies from 1.25 volumes to 1.35 volumes in the water as drawn in the tub at 74 degrees F. Thus the water is superior to that at Homburg and equal to the water at Kissingen or even Brückenau, or at Nauheim itself. No more gas can be held in solution in the water when released in the bath tub than Hathorn No. 1 mineral water contains naturally. The water therefore is used without any addition of artificial gas, for any of the series of CO_2 baths.

"The magnesium and calcium salts and the chlorides, all in solution, cause the requisite skin excitation and irritation, initiating the desired flow of blood to the surface. To the later series of the baths, alkali and common salt are added, as at Bad-Nauheim, when the mother-lye, or concentrated solids, are dissolved in the water from the No. VII, No. XII, or XIV Sprudel, the bathing waters of the famous spa of Hesse-Darmstadt.

"With careful diet, exercise and rest, as good results may be



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obtained at Saratoga Springs as at any locality in the world where CO_2 baths are administered."

H. S. B.

PUBLIC HEALTH SERVICE.

Great things have small beginnings. A spectacle-maker, Jan Leippersheim by name, living in Holland, invented a crude magnifying glass in 1608. Anton von Leuwenhoek, born in Delft, this day 1632, improved this clumsy toy and evolved a compound microscope which has become the most valuable sanitary tool yet devised by man. That first microscope was as far removed from the high-powered instrument of today as is the modern American from the original caveman. Yet by this faulty means, Leuwenhoek, naturalist, physician and botanist, discovered certain minute bodies which he called "little animals." He made drawings of these, and today we know them for those useful friends and malignant enemies of man—bacteria.

We spend our days surrounded by another world, a living world of countless billions, invisible to the naked eye, silent, tireless, destroying the living, consuming the dead, useful in the science and arts, yet often followed by a train of sickness, suffering and death. A curious paradox this, yet bacteria are at once the greatest friends and the fiercest foes of every living thing. Not animals, as Leuwenhoek thought, but vegetables, bacteria consist of two classes, those which prey on living things and those which reduce to their original minerals, fluids and gases every dead thing which they attack. They are of various shapes, round like marbles or straight like little sticks. They grow in clusters, chains and in pairs. They are ubiquitous. The dusty air, the earth and its waters, the interior of animals and plants all contain them. They cause the fermentation of foods, they make cheese, they produce disease, and some of them when killed and injected into an animal protect it against the very disease which they would have produced if living. Many of them live as harmless creatures in the body of an animal for years, only to kill their host when the opportunity presents. Their study has given birth to a science, bacteriology, one of the foundation stones of public health.

Their mere presence does not necessarily produce disease. Recalling the parable of the sower, some bacteria fall by the wayside, some fall upon stony places, and some fall in good ground and bring forth the fruit of suffering, perhaps of death. A normal, temperate life, free alike from the gluttony of idleness or overwork; the sound mind in the sound body; a cheerful, normal environment, these form the stony places in which bacteria take no root. The depraved appetites of mind and body, the dark and sordid atmosphere of penury, the nerve-racking and strength-undermining trades, these prepare the good ground.

The great weapon against bacteria is cleanliness. The mastery over premature death lies to a great measure in our own hands. Clean persons, clean cities, clean workshops and clean lives are the makers of public health. The United States Public Health Service and other sanitary bodies of this country are gradually bringing these facts home to the general public. In this way cleanliness is becoming more general and the span of life in America is gradually being lengthened. All of which is largely due to the microscope.

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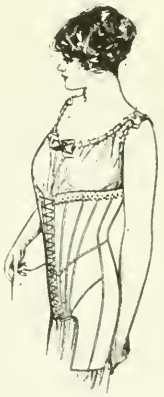

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THIS Directory is maintained mainly for the benefit of local firms seeking the patronage of physicians and their families. Only well established and reliable concerns will be represented, and doubtless the space at our disposal will be constantly in demand. In responding to these exploitations, the reader will find it mutually advantageous to mention the MARYLAND MEDICAL JOURNAL.

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HARDLY another of all the preparations in existence offers a wider scope to imposition under the plea of "just as good" than the scientifically standardized Eucalyptol.

The most recent fraud practiced in regard to this product is an attempt to profit by the renown of the firm of Sander & Sons. In order to foist upon the unwary a crude oil, that had proved injurious upon application, the firm name of Sander & Sons is illicitly appropriated, the make-up of their goods imitated, and finally the medical reports commenting on the merits of their excellent preparation are made use of to give the desired luster to the intended deceit.

This fraud, which was exposed at an action tried before the Supreme Court of Victoria at Melbourne, and others reported before in the medical literature, show that every physician should see that his patient gets exactly what he prescribed. No "just as good" allowed.

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There are scores of drugs listed in the materia medicas and pharmacopœias which have some direct or indirect action on the bowels. They exert their influence in various ways—mechanically, physiologically and medicinally—and all have more or less merit, as their use and recommendation go to indicate.

It should be remembered, however, that catharsis and purgation are properly never anything but emergency measures—to be used only "on the spur of the moment" when quick eliminative action is needed; as a consequence of which cathartic and purgative drugs have no place in the routine or systematic treatment of constipation. Gentle stimulation of the bowel, on the other hand, by means of mild but effective *laxatives* offers the more rational means of treating bowel inactivity, the commonest of the human ills, and should always be called upon when permanent benefits are sought. The

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effects of such measures will be prompt and decided, without pain, griping or distress of any kind, and since they are brought about by proper stimulation of physiological processes, they are naturally more prolonged and persistent.

Remedies that can accomplish such results are few and far between. Prunoids is one of the best of them, and its gentle but thoroughly satisfactory action in all forms of constipation, stasis and even intestinal atony, through its influence not only on peristalsis, but also on secretory activity, have made it the remedy of choice for this class of cases by thousands of physicians in all parts of the world. An opportunity to test its value will be given to all physicians who address the Sultan Drug Co., St. Louis, Mo.

K-Y Analgesic.

Most doctors realize that as a symptom, pain has, as a rule, considerable diagnostic significance. Sometimes, at least, if not often, the doctor is apt to overlook one fact, viz.: pain to the patient is a *condition*, not a symptom. He cares less for what it means than to get relief from it.

Hence the doctor is sometimes caught upon one horn of a double dilemma. To relieve pain by ordinary means, *i. e.*, hypodermatic injection or narcotic, given per os, is to satisfy the patient, but mask or alter the meaning of certain symptoms.

If the patient is left to suffer while the case is studied, the diagnosis is favored, but patient and friends resent what seems to them to be neglect. The use of opium or similar drugs to relieve pain is always fraught with danger; it's almost as bad as trying to cut off a dog's tail behind his ears! Nature has provided a means for pain relief or analgesia that deserves more careful and general use. In the arrangement of the sympathetic nervous system the spinal, distributing and reflecting centers lies the explanation of the good effect of counter-irritation and analgesia produced through the skin by local and external application.

And upon such natural physiological rules and working plans is based the action of the Anodyne "First-Aid," viz.: K-Y Analgesic.

Being greaseless and water-soluble, K-Y Analgesic when applied to the skin absorbs rapidly, penetrates deeply, relieves promptly and is more or less prolonged in action and effect. The analgesic agents contained in it—camphor, menthol and methyl salicylate—are active, but non-irritant or toxic, so that K-Y Analgesic can be applied as often as necessary and in any amount.

It does not stain the skin or soil clothing.

For the relief of headache, neuralgia, rheumatic pains, stiff and painful joints, lumbago, sprains, etc., K-Y Analgesic will be found to deserve a place in the doctor's mind—and in his bag, or on the shelf in his office.

How much good has been accomplished since the adoption of "first-aid" measures the doctor realizes and often has occasion to admit.

Then, since surgical "first-aid" is useful, both to patient and surgeon, why not Anodyne "first-aid"? Bearing in mind that the doctor is not called in, as a rule, until the patient has become alarmed at his or her condition, after simple or home treatment has failed to relieve, or is at the end of the ability to bear pain or discomfort, is it not better to depend upon Anodyne "first-aid" instead of the dose of opiate, narcotic or "coal tar" taken by the patient on his or her own responsibility?

Anodyne "first-aid" refers, for example, to K-Y Analgesic. K-Y Analgesic makes Analgesia attainable by the use of an external application.

Being greaseless and water-soluble, K-Y Analgesic absorbs quickly, differing, therefore, in this important property from grease or oil (the ordinary ointment or lotion bases).

It penetrates deeply, so that real analgesic effect is added to the property of counter-irritation.

It relieves promptly, and, what is most important, its effect is generally prolonged.

Furthermore, being itself incapable of doing harm, K-Y Analgesic can be used ad libitum, and as often as necessity dictates.

It does not stain skin or soil clothing. It washes off quickly and easily.

For the relief of pain, such as neuralgia, headache, rheumatic, or to relieve soreness, such as in sprains, stiff joints, lumbago, etc., K-Y Analgesic will prove a reliable and useful Anodyne "First Aid" to keep the patient comfortable between the doctor's visits and to enable him to attain analgesia without having to use agents internally or hypodermatically whose action might mark important symptoms or modify them so as to obscure or delay diagnosis.

A man does not see with his eyes or hear with his ears.

He sees and hears with his *brain*.

He also feels pain—with his *brain*.

Irritation or stimulation, applied to a sensory or even to a motor nerve, is reflected and

transferred to the brain and pain sensation registered. Much pain is referred to some surface area, *e. g.,* the pain in purlatic disease that is felt in the sole of the foot.

Hence counter-irritation, or even analgesia applied over a surface area which is registering pain, has the effect in most instances of relieving that pain.

It is preferable in many cases to secure analgesia by means of external application instead of giving anodynes per os or hypodermatically.

K-Y Analgesic makes such analgesia attainable.

It is, in fact, an Anodyne "First Aid."

By virtue of its contained camphor, menthol and methyl salicylate it is active, yet non-irritant. It does not blister, stain the skin or soil the clothing; moreover, it is water-soluble, can be easily removed and applied as often as may be found necessary. An especially valuable advantage is that it is *greaseless.*

Which assures prompt absorption, deep penetration and quick as well as prolonged action and effect.

K-Y Analgesic is intended for the relief of headache, neuralgia, rheumatic pain, soreness or stiffness of muscles or joints, lumbago, sprains, contusions, etc.

It will prove a valuable aid to be used until the doctor can get in touch with his patient or to keep the latter comfortable between his visits. K-Y Analgesic will prove to be a good investment for the doctor to make; it will save him trouble and annoyance, and secure the gratitude of his patients.

Convalescence.

The secret of prompt recovery from many a serious illness will be found in the prompt institution of tonic treatment. The resulting uplift is often all that is needed to enable the body to re-establish a nutritional balance and develop adequate resistance.

Thus, after the acute diseases, such as typhoid fever, pneumonia, pleurisy, influenza, or those requiring surgical operations like appendicitis, intestinal ailments, utero-ovarian ailments and so on, the return to health often hinges on the thought and care given to restorative treatment. If a reconstructive like Gray's Glycerine Tonic Comp. is used, the result is rarely if ever in doubt. Unlike many remedies used to promote convalescence, Gray's does not whip up weakened forces. On the contrary, it aids and reinforces them by increasing the power and capacity of physiologic processes throughout the body. Thus the appetite is improved, digestive and absorptive functions are activated and the resulting improvement in cellular nutrition insures a notable gain in vitality and strength. Weakness and debility vanish as vitality and strength appear. This tells why "Gray's" is so useful and effective after the acute diseases.

Estimating Drug's Merit.

In estimating the value of BROMIDIA (Battle) the features that should receive full consideration are its definite therapeutic potency and its freedom from the production of disagreeable after-effects, which latter, unfortunately, so frequently tend to neutralize the therapeutic efficiency of extemporaneously prepared bromide mixtures.

As a result of these advantages of BROMIDIA, it has come into wide use as a simple hypnotic agent, especially in those states presenting a marked nervous element. Its marked sedative properties reduce nervous tension, and thus composing the sleepless patient, permit a more prompt and decided hypnotic action, BROMIDIA (Battle) will be found an ideal agent in insomnia, for the rest it produces is refreshing and is not followed by depression or other disagreeable after effects. With a minimum dosage a full sedative influence is exerted. The drugs entering into the composition of BROMIDIA, which need not be given here, for it is generally known, are chosen with the utmost care as to therapeutic power and purity.

BROMIDIA (Battle) is a very practical, matter-of-fact formula, its superiority resting entirely upon purity of components and skill in manufacture. Its present-day wide use has been gained through its meeting severe clinical demands.

Phylacogen in Pneumonia.

Perhaps no disease has baffled medical treatment to a greater extent than has lobar pneumonia. It must be conceded that as yet there is no true specific for the disease. The mortality from this type of pneumonia is high as compared with that of most other infectious diseases. In view of these facts, any agent that nearly approaches the specific in lobar pneumonia should be welcomed by the medical profession. Pneumonia Phylacogen is believed to merit that distinction.

In the use of Pneumonia Phylacogen, as in that of the various other Phylacogens, observance of certain details of administration may have an important bearing on the results. The product may be administered either subcu-

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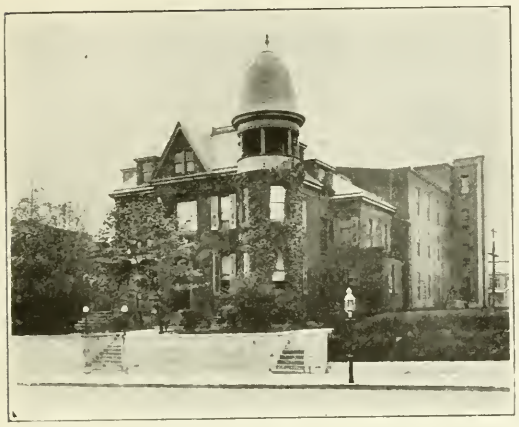

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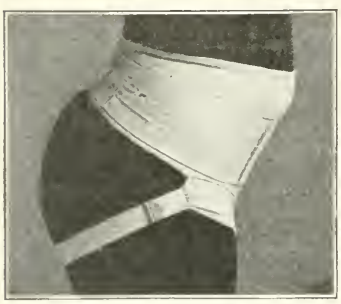

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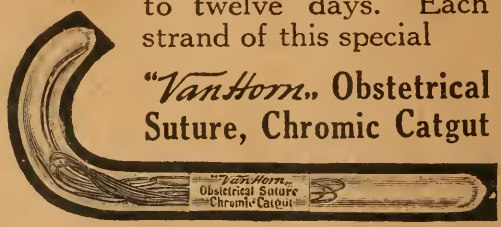

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